COVID-19 SCREENING CHECKLIST

CLIENT NAME: ________________________________

DATE: ________________________________

HAVE YOU OR ANYONE YOU’VE HAD CONTACT WITH:

1. Traveled on a plane in the last 14 days
   YES or NO
2. Been exposed to or confirmed diagnosis of COVID-19?
   YES or NO
3. Have a fever over 100.0 F?
   YES or NO
4. Have a cough or sore throat?
   YES or NO
5. Have signs of shortness of breath or difficulty breathing?
   YES or NO
6. Have a headache?
   YES or NO
7. Have unusual fatigue or muscle pain?
   YES or NO
8. Have a new loss of smell?
   YES or NO
9. Have signs of gastrointestinal illness such as loss of appetite, diarrhea, vomiting, or abdominal pain?
   YES or NO
10. Have chills and/or repeated shaking with chills?
    YES or NO

If you answered YES to any of these questions, we ask you to contact your primary care provider immediately for further instructions and we will reschedule your appointment.

The technician will review again at your appointment.

If you answered NO to all questions we will proceed with a no contact temperature check.

________________________________________  __________________________
CLIENT SIGNATURE                           DATE

OFFICE USE ONLY – DAY OF APPOINTMENT:

Recorded Temperature: ________________________________

Technician: ________________________________

Date: ________________________________
Full Name: ____________________________________________
  First __________________ Middle ___________________ Last __________________

Date of Birth: ________________________________

Address: __________________________________________ City: ____________ St: ___ Zip: __________

Home Phone: __________________________ Work Phone: ______________ Cell: ______________

Email Address: ________________________________________________________________

**BREAST EXAMS ONLY:**

**Is this exam due to an abnormal mammogram? Yes or No**
If yes, please bring in any previous reports or discs with images you have to your appointment.

**Have you ever been diagnosed with breast cancer? Yes or No**
If yes, please elaborate on any breast cancer history, biopsies, the type of cancer, date diagnosed, date biopsied, location of biopsy, location of the mass or lump, treatments, etc. Please bring in any previous reports or discs you have to your appointment.

________________________________________________________________________________________________________

________________________________________________________________________

**ALL EXAMS:**
Please provide a brief history of the reason for your exam today including any current or previous concerns or health issues specific to the area we are examining.

________________________________________________________________________________________________________

**Have you had an ultrasound of this same area before? Yes or No**
(If yes continue to next question)

**Was your previous exam done with our company? Yes or No**
(If no please bring a copy of your previous report and/or disc with images to your appointment for us to upload to the Radiologist for comparison.)

**Allergies:**
List any allergies and PLEASE inform our staff if you have an allergy to Latex.

________________________________________________________________________________________________________

**Referring Physician Name:** ____________________________________________

Phone: __________________________ Fax: __________________________

*Mobile Thermographic & Ultrasound Imaging will automatically provide a report to your referring physician. Please contact their office to review your results.*

I verify the accuracy of the information above. I authorize **Mobile Thermographic Imaging**, which has treated me, or my dependent to furnish any medical information requested. I understand that I am financially responsible for the charges related to this ultrasound examination.

Patient Signature: __________________________ Date: _______________
Patient consent for use and disclosure of protected health information and pre-exam acknowledgement

I hereby give my consent for Mobile Thermographic Imaging to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

Mobile Thermographic Imaging reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy practice may be obtained by forwarding a written request to Mobile Thermographic Imaging at 21 W. Terracedale Ct. Griffin, GA 30224.

With this consent, Mobile Thermographic Imaging may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and any calls pertaining to my clinical care. No test results, however, will be left on voicemail or with any other person without a specific request by me to do so.

With this consent, Mobile Thermographic Imaging may email or mail to home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

I have the right to request that Mobile Thermographic Imaging restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Mobile Thermographic Imaging use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to extent that the practice has already made disclosures in reliance upon my prior consent.

With regards to my examination, I understand that I may be required to remove certain garments and wear a hospital gown. I also understand that the technologist performing my exam must maintain a close proximity to me during the examination and must engage in contact with the area being examined to satisfy the logistical requirements for successful completion of the exam. I understand that this is necessary and will be executed in a strictly professional manner with respect to my dignity and privacy. I waive any liability to Mobile Thermographic Imaging should I suddenly find objection to this during my examination.

I understand that the report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the report is not intended to be used by individuals for self-evaluation or self-diagnosis. By signing below, I certify that I have read and understand the statements above and consent to the examination. I verify my information is correct and I understand I am responsible for my bill.

Print Name of Patient

Signature of Patient (If Minor, Signature of Parent or Legal Guardian) Date Signed
PAYMENT AGREEMENT & FINANCIAL POLICY
SELF-PAY DIAGNOSTIC CLIENT

CLIENT NAME: ____________________________________________________________
DATE OF BIRTH: __________

CHARGES: I understand that I am and will be responsible for all charges related to the services provided to me by Mobile Thermographic Imaging (aka MTI); and that the charges presented to me are due in full prior to my appointment, unless previous arrangements have been made with the accounting department; and that these charges are solely in relation to professional services provided by MTI and the interpreting Radiologist; and that all other testing such as mammography, blood labs or follow up physician visits are not related to MTI and are my sole responsibility; and that the charge for this exam does not include any other additional exams.

INSURANCE: MTI does not file insurance. If you have received a doctor’s order for this exam you will receive a detailed receipt to submit to your insurance. If ultrasound is covered under my insurance policy, it is my sole responsibility to file and obtain reimbursement from my insurance company and that it still is not a guarantee of coverage. Flexible Spending Account, Health Savings Account and Aflac have accepted and reimbursed for various exams, this however is not a guarantee of coverage.

Cancellations: You may cancel or reschedule 48 hours prior to your appointment and receive a refund of your payment. Cancellations made within 48 hours of your appointment are non refundable.

The Client certifies that he or she has read and agreed to the forgoing, and if requested, has received a copy thereof, and is the client or the client’s representative and accepts its terms.

SIGNATURE OF CLIENT OR CLIENT’S AUTHORIZED REPRESENTATIVE __________________________ DATE ____________________
Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I received a copy of the Notice of Privacy Practices.

Effective dates for this Authorization: Today’s date _____/_____/_____ through _____/_____/_____(expiration of this Authorization form). Medical records are kept for only seven years. In order to keep your file updated, Mobile Thermographic Imaging provides client with a new Authorization form to sign each year.

Patient Name: 

(Please print)

Signature of Patient/Parent (if patient is a minor):

Date: ________________

If not signed by the patient please indicate the relationship to the patient:

___________________________________________